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In The
Supreme Court of the United States

ALFRED GOBEILLE, in his official capacity as chair of the Vermont Green Mountain Care Board,
Petitioner,

v.

LIBERTY MUTUAL INSURANCE COMPANY,
Respondent.

On Writ Of Certiorari To The United States Court Of Appeals For The Second Circuit

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INTRODUCTION

This Court's precedents, including *Travelers* and *De Buono*, recognize that Congress did not intend ERISA to displace state health care regulation. Vermont's health care database law falls squarely within that historical, non-preempted state role: it is "designed to improve the quality, utilization, and cost of healthcare in Vermont by providing consumers, government officials, and researchers with comprehensive data about the healthcare-delivery system." U.S. Br. 11. To do their jobs effectively, regulators and policymakers need accurate information about health care expenditures. Those critical health care spending data are necessarily held by a wide range of payers, including federal and state government programs, private insurers, and third-party administrators of ERISA plans. Vermont's collection of claims data from all payers through a generally applicable health care law does not intrude on the areas that ERISA reserves to federal law.

Liberty Mutual's brief says little about the Court's controlling decisions in *Travelers* and *De Buono* or state authority to regulate health care. Instead, Liberty Mutual argues that providing claims data is unacceptably burdensome for plans. This Court, however, has held that incidental burdens and administrative costs for ERISA plans are insufficient to warrant preemption of a generally applicable state health care law. In any event, despite the pages Liberty Mutual devotes to this point, the record is silent. Even after prodding by the district court in this case, Liberty Mutual was unable to produce any evidence of cost or burden—and there is none.

The strong showing of *amicus* support for Vermont's law from States, policymakers, health care providers,

and researchers highlights the importance of these comprehensive health care databases. They provide the information needed to grapple with the complexity and cost of our nation's health care system. They support policies and research that improve patient care and outcomes. And they serve not just state purposes, but federal objectives as well. Liberty Mutual has not shown that preemption is warranted here.

I. This Court's established precedents confirm that Vermont's health care database statute is not preempted.

The principles set forth in *Travelers*, *De Buono*, and related precedent control the analysis here and require reversal of the decision below. Liberty Mutual's bare acknowledgement of the Court's central decisions addressing ERISA preemption and state health care laws highlights the weakness of its position. And the new rule for preemption that Liberty Mutual offers—that States are preempted from gathering any information from self-insured plans that relates to the provision of benefits—is not supported by ERISA's text, its legislative history, or this Court's decisions.

A. Liberty Mutual disregards the Court's settled framework for ERISA preemption.

Under the framework this Court adopted in *Travelers* and re-affirmed in *De Buono* and *Dillingham*, Vermont's database statute is not preempted.[1] The

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[1] Respondent's *amici* argue that the Court should overrule *Travelers* and adopt new tests for ERISA preemption. *See* BCBSA Br. 4-18; New England Legal Found. Br. 3-12. As the parties have not argued that the Court should overrule its precedents, the issue is not properly before the Court. *See, e.g.*, *Burwell v. Hobby Lobby Stores, Inc.*, 134 S. Ct. 2751, 2776

Court confronted in *Travelers* precisely the question raised by this case: did Congress intend ERISA to broadly preempt state health care regulations? The Court concluded that "nothing in the language of [ERISA] or the context of its passage indicates that Congress chose to displace general health care regulation, which historically has been a matter of local concern." *Travelers*, 514 U.S. 645, 661 (1995). Vermont's all-payer claims database (APCD) regulates health care, not employee benefit plans, and it does not intrude on ERISA's core objectives. It is not preempted.

1. The United States agrees, and Liberty Mutual does not dispute, that Vermont's statute "operate[s] in the traditional state sphere of health and safety." U.S. Br. 11. States use these databases to design strategies to control costs while improving the quality of care; support health care research; regulate insurers and providers; and evaluate and improve public health policy. *See* Pet. Br. 12-16, 31-35.[2] Because

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(2014). In any event, *amici* do not offer a credible argument for overturning this longstanding body of precedent. *Stare decisis* has "special force" in the context of statutory interpretation, because "Congress remains free to alter" what the Court has decided. *John R. Sand & Gravel Co. v. United States*, 552 U.S. 130, 139 (2008) (quotations omitted). In the 20 years since *Travelers*, the Court has re-affirmed its holding and Congress has not modified the Court's interpretation of ERISA's preemption clause. *See Watson v. United States*, 552 U.S. 74, 82-83 (2007) (relying in part upon "long congressional acquiescence" over 14-year period as support for applying *stare decisis*); *Pegram v. Herdrich*, 530 U.S. 211, 237 (2000) (re-affirming *Travelers* standard).

[2] *See also, e.g.*, U.S. Br. 16 (database serves "variety of general healthcare related goals"); N.Y. Br. 12-20 (providing examples related to public health, insurance regulation, transparency, and cost control); NGA Br. 10-14 (similar); N.H. Br. 14-

the database statute "operates in a field that has been traditionally occupied by the States," Liberty Mutual bears a "considerable burden" to establish preemption. *De Buono*, 520 U.S. 806, 814 (1997) (quotations omitted). "[I]n the field of health care, a subject of traditional state regulation, there is no ERISA preemption without clear manifestation of congressional purpose." *Pegram*, 530 U.S. at 237

2. Requiring third-party administrators, like all health care payers, to provide standardized paid claims data to Vermont's database does not intrude on ERISA's core objectives. Those objectives, distilled from the statute's text and this Court's precedents, are: (i) protecting beneficiaries by establishing fiduciary standards and ensuring plans pay promised benefits; (ii) creating an exclusive federal enforcement mechanism; and (iii) establishing a uniform body of federal law governing the provision and funding of benefits. Pet. Br. 25-29. State APCDs—which collect claims data from all payers to gain a comprehensive picture of health care spending—serve purposes unrelated to these core ERISA objectives. And APCD laws have no impermissible effect on plans because plan administrators generate claims data in the ordinary course of business. Collecting this after-the-fact data does not insert the State into the plan's operations or into the relationship between a plan and its members.

Preemption does not occur simply because a generally applicable law has some effect on a plan—here, by requiring the plan to provide the same data as other health care payers. The Court repeatedly has upheld state laws that affect plans but do not regu-

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19 (insurance regulation); CHLPI Br. 13 (research that "directly impacted patient care").

late the core areas that ERISA reserves to federal law. In *Mackey*, the Court upheld the application of state garnishment statutes to ERISA plans, over the objection that garnishment proceedings involved "substantial administrative burdens and costs." 486 U.S. 825, 831 (1988). As the Court later explained, it "took no issue" with the claim that garnishment would impose "costs and burdens upon benefit plans" but held that Congress nonetheless did not intend to preempt state laws that impose "an indirect source of administrative cost." *Travelers*, 514 U.S. at 662 (citing *Mackey*, 486 U.S. at 831-32).

In *Travelers*, building upon *Mackey*, the Court upheld New York's hospital-rate surcharges, which required hospitals to charge commercial insurers (including insured ERISA plans) 24% more than Blue Cross/Blue Shield payers. *Id.* at 650, 668. *De Buono* sustained a state tax on gross receipts of health care facilities, as applied to facilities directly operated by ERISA plans. 520 U.S. at 809-10. The Court recognized that the tax increased the cost of providing benefits and had "some effect on the administration of ERISA plans," but, the Court emphasized, "that simply cannot mean that every state law with such an effect is pre-empted." *Id.* at 816. And, in *Dillingham*, the Court held that California's prevailing wage law was not preempted by ERISA, even though ERISA apprenticeship plans were put to the choice of complying with state-law standards or paying a higher wage to apprentices. 519 U.S. 316, 332-34 (1997).

These decisions confirm that, despite the breadth of ERISA's preemption clause, Congress intended neither to insulate plans from all state regulation nor to displace "traditionally state-regulated substantive

law" in areas where ERISA "has nothing to say." *Id.* at 330; *see also De Buono*, 520 U.S. at 815 (describing tax as "one of myriad state laws of general applicability that impose some burdens on the administration of ERISA plans" but are not preempted) (quotations omitted). Vermont's law stays well clear of ERISA's concerns because it does not regulate how plans operate *as plans*. The Court has described an ERISA "plan" as a "scheme decided upon in advance" that "comprises a set of rules that define the rights of a beneficiary and provide for their enforcement." *Pegram*, 530 U.S. at 223. The "provisions that constitute a plan" include "[r]ules governing collection of premiums, definition of benefits, submission of claims, and resolution of disagreements over entitlement to services." *Id.* The database statute does not regulate these matters and does not define the rights of beneficiaries or provide for their enforcement. It is not preempted.

B. Liberty Mutual's cursory effort to distinguish controlling precedent is unpersuasive.

1. Instead of grappling with the Court's reasoning in *Travelers* and *De Buono*, Liberty Mutual tries (at 53) to distinguish the cases on their facts, asserting that Vermont's statute "has an entirely different focus" from health care surcharges and taxes. In fact, both *Travelers* and *De Buono* involved much broader state health policy goals. *See De Buono*, 520 U.S. at 809 (noting that New York imposed tax on gross receipts for health care facilities to address Medicaid deficit); *Travelers*, 514 U.S. at 658-59 (describing policy bases for surcharges on commercial insurers and HMOs). The Court in *Travelers* recognized this broader context, noting that "Congress

never envisioned ERISA pre-emption as blocking state health care cost control, but rather meant to encourage and rely on state experimentation like New York's." 514 U.S. at 667 n.6.

APCDs, like the taxes and surcharges upheld in *Travelers* and *De Buono*, are tools that States use to manage their health care systems better and more efficiently. Indeed, databases are closely suited to this task, because they "provide policymakers with information they can use to develop programs that improve the quality of health care while controlling costs." N.Y. Br. 10. The Court's reasoning in *Travelers* and *De Buono* applies with equal force to state health care databases.

Liberty Mutual mistakenly implies (at 54) that the regulations upheld in *Travelers* and *De Buono* had little relevance to plans, and applied to them only by "happenstance." Not so. The hospital-rate surcharge upheld in *Travelers* applied to the benefit payments made by insured plans—that is, plans insured by commercial insurers paid 24% more for the same services than Blue Cross carriers paid. 514 U.S. at 650.[3] That surcharge—partly a tax turned over to the State—thus affected how insured plans paid for employee health benefits. Similarly, in *De Buono*, the Court upheld a tax on health care services as applied to plan-run health care facilities. 520 U.S. at 809-10. That tax applied directly to the plan's provision of benefits to its members. These state taxes and surcharges were upheld notwithstanding their effects on benefit plans, because Congress did

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[3] In *Travelers*, the Blue Cross entities opposed preemption, relying on the "strong presumption against preemption where the challenged law was based upon the states' traditional police powers." Pets. Br. 28, *Travelers*, 514 U.S. 645 (No. 93-1408).

not intend ERISA to override ordinary state health care regulations. *See id.* at 813-16; *Travelers*, 514 U.S. at 654-55, 661-62, 664-67.

2. Liberty Mutual's alternative argument (at 44-47) that providing claims data to Vermont conflicts with 29 U.S.C. § 1104(a)(1)(D)—which requires plan fiduciaries to act "in accordance with the documents and instruments governing the plan"—also lacks merit. As the United States has shown, complying with Vermont's law does not conflict with Liberty Mutual's plan documents. *See* U.S. Br. 32-34. Indeed, the primary plan document, which controls plan terms, says the plan will comply with "state and federal law to the extent not preempted by ERISA." JA57.

In any event, the Court has rejected the argument that § 1104(a)(1)(D) preempts any state law that may be contrary to a plan term. *UNUM Life Ins. Co. v. Ward*, 526 U.S. 358, 375-76 (1999). Although, as Liberty Mutual notes (at 45), *UNUM* was decided under ERISA's savings clause for laws relating to insurance, the Court's holding did not turn on the language of that clause but on the illogic of the argument. *Id.* The scope of state regulatory authority cannot depend, plan by plan, on provisions that employers choose to include in plan documents.

Nor does *Egelhoff* support Liberty Mutual's alternative argument. There, the Court held preempted a state law that overrode the plan terms governing beneficiary designations. That "implicate[d] an area of core ERISA concern," because administrators would have to "pay benefits to the beneficiaries chosen by state law, rather than to those identified in the plan documents." 532 U.S. 141, 147 (2001). Nothing in *Egelhoff* suggests that plans can expand

ERISA preemption and circumvent otherwise applicable state law merely by including contrary language in plan documents.

C. Liberty Mutual's proposed new test is not supported by ERISA's text or legislative history and cannot be reconciled with this Court's precedents.

Rather than address controlling precedent or defend the approach taken by the decision below, Liberty Mutual offers a new test, arguing that ERISA preempts any state-law requirement that plans provide information touching upon the provision of benefits. Liberty Mutual relies heavily on selected excerpts from ERISA's extensive legislative history. But neither ERISA's text nor its legislative history supports Liberty Mutual's position. And the rule it proposes cannot be reconciled with *Mackey*, *Travelers*, *De Buono*, and *Dillingham*.

1. Liberty Mutual's proposed test relies (at 13) on the premise that one of Congress's "principal objectives" in passing ERISA was to reduce reporting burdens on plans. This suggestion that ERISA's reporting and disclosure standards were intended to reduce *all* administrative burdens finds no support in the statute's text. ERISA's reporting requirements are "extensive" and "elaborate." *Dillingham*, 519 U.S. at 327; *Massachusetts Mut. Life Ins. Co. v. Russell*, 473 U.S. 134, 139 n.7 (1985). And ERISA's text confirms that its reporting requirements were intended to protect beneficiaries, not to lighten administrative burdens. *See* 29 U.S.C. § 1001(b) (declaring policy to protect "the interests of participants in employee benefit plans and their beneficiaries" in part by requiring "disclosure and reporting . of financial and other information"); *id.* § 1001(a) (noting "lack

of employee information and adequate safeguards concerning [plan] operation"; need for "disclosure" and "safeguards"; and concerns with "soundness and stability of plans" and loss of anticipated benefits). The reporting and disclosure provisions require information about plan financing, actuarial soundness, adherence to fiduciary standards, and participants' rights—information regulators and participants need to ensure that plans are managed appropriately. *See id.* §§ 1021-1025. This Court repeatedly has recognized that ERISA's reporting, disclosure, and fiduciary requirements were intended to protect beneficiaries from mismanagement and failure to pay benefits. *See Dillingham*, 519 U.S. 326-27; *Morash*, 490 U.S. 107, 115 (1989).

Neither Vermont nor the federal government has suggested that ERISA leaves States generally "free to impose their own reporting requirements." Resp. Br. 16. Rather, the nature and purpose of ERISA's reporting requirements guide the preemption inquiry. Requirements that "effectively invade the field exclusively governed by ERISA and alter the approach that Congress adopted to ensure that plans are administered according to appropriate legal requirements" are preempted. U.S. Br. 16; *see* Pet. Br. 22-23. Collecting standardized data on paid health claims to serve traditional state purposes, however, falls comfortably outside the field that ERISA governs.[4]

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[4] The Affordable Care Act's (ACA) "technical amendment" to Part 7 of ERISA does not change the analysis. *See* Pub. L. No. 111-148, § 1562(e), 124 Stat. 119, 270 (codified at 29 U.S.C. § 1185d). The ACA amended ERISA to incorporate a number of the ACA's market reforms, including requirements that health plans report on their finances, claims policies, and how their

2. Liberty Mutual's selective citation to ERISA's voluminous legislative history is unconvincing. Much of what Liberty Mutual culls from predecessor bills and members' statements shows merely that Congress intended a significant degree of federal preemption and wanted plan reporting, disclosures, and fiduciary standards to be governed by federal law. Neither proposition is disputed—and neither decides this case. Moreover, Liberty Mutual's recounting of legislative history is flawed in several key respects.

First, ERISA's legislative history confirms that the reporting and disclosure requirements were intended to protect and inform beneficiaries. *See* AARP Br. 15-18. Even Liberty Mutual's excerpts show that Congress treated plan reporting as linked with other aspects of plan governance, including funding, fiduciary standards, and disclosures. *See, e.g.*, S. Rep. No. 93-127, at 35 (1973) (addressing "single reporting and disclosure system" together with standards for "vesting, funding, insurance and portability standards,

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benefits comply with the ACA's coverage goals. *Id.* §§ 1001, 1562(e), 10101, 124 Stat. 130-38, 270, 883-91; *see also* 42 U.S.C. §§ 300gg-15a, 300gg-17, 300gg-18. *Amicus* Blue Cross and Blue Shield Association mistakenly argues (at 21-28) that this amendment expands ERISA preemption. *First*, like ERISA's reporting and disclosure provisions, the ACA amendment ensures that plans fulfill their benefit promise—including by providing ACA-mandated coverage. *Second*, the ACA states "[n]othing in [Title I, which includes the relevant provisions,] shall be construed to preempt any State law that does not prevent the application of [Title I]." 42 U.S.C. § 18041(d). And, *finally*, Part 7 of ERISA—which now incorporates the new provisions—expressly provides that "[n]othing in this part shall be construed to affect or modify the provisions of" § 1144 "with respect to group health plans." 29 U.S.C. § 1191(a)(2); *see also* U.S. Br. 21-22.

[and] evaluating fiduciary conduct"), *reprinted in* 1974 U.S.C.C.A.N. 4838, 4871; S. 3589, 91st Cong. § 14 (1970), *in* 116 Cong. Rec. 7284 (1970) (prior bill, addressing preemption of "fiduciary, reporting and disclosure responsibilities"). The statement from Senator Javits, which Liberty Mutual edits (at 19), described the preempted "field of private employee benefit programs":

> In view of Federal preemption, State laws compelling disclosure from private welfare or pension plans, imposing fiduciary requirements on such plans, imposing criminal penalties on failure to contribute to plans—unless a criminal statute of general application—establishing State termination insurance programs, et cetera, will be superseded. It is also intended that a body of Federal substantive law will be developed by the courts to deal with issues involving rights and obligations under private welfare and pension plans.

120 Cong. Rec. 29,942 (1974). This fuller context illustrates why Liberty Mutual's reading of legislative history is flawed. Comments like these do not suggest Congress intended to preempt state health care regulations unrelated to plan governance.

Second, although some legislators may have questioned the wisdom of dual regulation by the Departments of Labor and Treasury, the debate over agency roles involved much broader political issues.[5] And, regardless, Congress did not centralize plan oversight in one agency. ERISA instead exhorted

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[5] *See generally* James A. Wooten, *Employment Retirement Income Security Act of 1974: A Political History* 178, 185-89, 200-05, 250-51 (2004) (discussing competing views of labor and business interests and committee-jurisdiction issues related to agency oversight).

both agencies to "consult" and adopt rules and practices that "reduce duplication . . . of reporting" to "the extent appropriate." 29 U.S.C. § 1204(a). Further, the text conveys concern with the cost to the federal government, not just to plans. *See id.* § 1204(b) (affording discretion to cooperate "to avoid unnecessary expense and duplication of functions among Government agencies"). Given that resolution, the issue hardly warrants the emphasis Liberty Mutual places on it.

Third, Liberty Mutual's assertion (at 23) that Congress "clearly considered" claims data to be part of plan reporting far outstrips anything Liberty Mutual cites from ERISA's text or legislative history. The standardized electronic claims data that APCDs collect did not exist in 1974. Liberty Mutual also places substantial weight on what seems to be a misreading of ERISA's legislative history, suggesting (at 23) that Congress viewed "claims information" as "extremely burdensome" to provide and amended the proposed bill to remove the requirement to report total benefits paid by the plan. ERISA has always required an annual "statement of receipts and disbursements . . . aggregated by general sources and applications." Pub. L. No. 93-406, § 103(b)(3)(B), 88 Stat. 829, 844 (codified at 29 U.S.C. § 1023(b)(3)(B)).[6]

In any event, draft bills and committee reports have far less relevance than contemporaneous federal statutes that acknowledged and promoted States' health data collection and States' broader role in

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[6] *See* Dep't of Labor, Form 5500, Schedule H (requiring reporting of "[t]otal benefit payments"), http://www.dol.gov/ebsa/pdf/2014-5500-Schedule-H.pdf; *id.*, Schedule I (similar), http://www.dol.gov/ebsa/pdf/2014-5500-Schedule-I.pdf; *see also* U.S. Br. 2 (noting certain reporting exemptions for welfare plans).

regulating the health care market. The same Congress that enacted ERISA also passed the Health Services Research, Health Statistics, and Medical Libraries Act of 1974. The Act (which Liberty Mutual does not discuss) formally established the National Center for Health Statistics and directed the Center to support and cooperate with state agencies. Pub. L. No. 93-353, §§ 104, 105, 88 Stat. 362, 364-66 (codified as amended at 42 U.S.C. § 242k). That law confirms that Congress both saw a need for data on health care costs, financing, and utilization, and expected the federal government to work with state government to collect those data. *See id.* If there were any doubt on that point, that same Congress also passed the National Health Planning and Resources Development Act of 1974. That statute, as the Court recognized in *Travelers*, supported States' health care planning and regulation and funded regional agencies responsible for collecting health care data. Pub. L. No. 93-641, §§ 1521-1526, 88 Stat. 2225, 2242-50 (1975); *Travelers*, 514 U.S. at 665-67. Given this contemporaneous evidence of congressional views, ERISA should not be interpreted to bar States from collecting comprehensive health care data.

3. Liberty Mutual's sweeping rule—that any state reporting requirement related to a plan's provision of benefits is preempted—cannot be reconciled with this Court's precedents. The plan-run facilities in *De Buono* provided medical care to members—a plan function expressly contemplated by ERISA. *See* 520 U.S. at 810; 29 U.S.C. § 1002(1). New York's tax on their gross receipts was directly tied to the provision of benefits and necessarily would have required reporting for calculating and enforcing the tax. The garnishment statute in *Mackey* required plans not

only to provide information about benefits, but to pay into court "funds due the beneficiary-debtor—funds that otherwise they are required to hold and pay out" to beneficiaries. 486 U.S. at 831. And garnishment was triggered by "an activity that is the essence of an employee welfare benefit plan," Resp. Br. 24—namely, providing benefits. While *Dillingham* did not directly address reporting requirements connected to prevailing wage statutes, courts of appeals have declined to hold prevailing wage laws preempted based on their recordkeeping mandates.[7]

Because ERISA contemplates that plans may offer a range of benefits, including health care, day care centers, training programs, scholarship funds, and legal services, 29 U.S.C. § 1002(1), Congress could not have intended to preempt *all* reporting requirements that reflect or touch on plan benefits. Not even Liberty Mutual supposes that Congress intended employer-run day care centers or hospitals to be unlicensed and unregulated. *See* Resp. Br. 54. But its argument that these plan-run facilities are not engaged in the "core plan activity of providing benefits," *id.*, conflicts with ERISA's text, which contemplates plans providing those very services "through the purchase of insurance *or otherwise*." 29 U.S.C. § 1002(1) (emphasis added); *see also id.* § 1191b(b)(1) (defining "health insurance coverage" under ERISA as medical care "provided directly, through insurance

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[7] *See, e.g., WSB Elec., Inc. v. Curry*, 88 F.3d 788, 795 (9th Cir. 1996) (upholding prevailing wage statute, over objection that employer would be obligated to keep "detailed" records showing benefit contributions); *Keystone Chapter, Assoc. Builders & Contractors, Inc. v. Foley*, 37 F.3d 945, 962-63 (3d Cir. 1994) (similar).

or reimbursement, or otherwise"). Liberty Mutual's rule is unworkable.

Travelers, *De Buono*, *Mackey*, and *Dillingham* articulate a central principle: that administrative burdens are not a sufficient basis for insulating ERISA plans from ordinary state regulations in fields, like health care and wage laws, "where ERISA has nothing to say." *Dillingham*, 519 U.S. at 330. Liberty Mutual seeks to transform the reporting of information into a special kind of administrative burden that triggers preemption. As text, legislative history, and precedent show, however, ERISA mandates uniform plan reporting and disclosure requirements that serve the statute's purposes. It does not bar States from obtaining information from plans.

II. Providing standardized, after-the-fact claims data does not interfere with uniform plan administration or otherwise burden plans in a manner that warrants preemption.

Liberty Mutual and its *amici* argue that the burden of complying with Vermont's database law warrants preemption. Generally applicable health care laws are not preempted simply because they "impose some burdens on the administration of ERISA plans." *De Buono*, 520 U.S. at 815; *Dillingham*, 519 U.S. at 334; *Travelers*, 514 U.S. at 668. To the contrary, preemption will be found only if the burden is so substantial that it interferes with a plan's ability "to establish a uniform administrative scheme . . . to guide processing of claims and disbursement of benefits," *Egelhoff*, 532 U.S. at 148 (quotations omitted), or forces the plan "to adopt a certain scheme of substantive coverage," *Travelers*,

514 U.S. at 668. Liberty Mutual has not come close to making that showing.

First, Liberty Mutual submitted no evidence that complying with Vermont's database law would affect the administration of its medical plan. Below, Liberty Mutual argued that evidence of the actual cost or burden of complying with Vermont's database statute was irrelevant. *See* Pet. Br. 54. The district court questioned this point at the summary judgment hearing, noting that "there doesn't seem to be a whole lot of information" on the potentially "fundamental question: How burdensome is this on Blue Cross-Blue Shield to turn over this information?" C.A. JA356. Liberty Mutual's counsel insisted that "the extent of the burden . . . doesn't matter" and that the district court did not "have to weigh the relevant burden." C.A. JA356-57. Liberty Mutual thus made no evidentiary showing, despite multiple opportunities to do so. *See, e.g.*, App. 39 (Straub, J., dissenting) (Liberty Mutual "failed to provide any details or showing of the alleged burden"); JA5 (docket showing post-hearing submission addressing other issues).

Liberty Mutual did not merely fail "to quantify the administrative costs" associated with complying with the Vermont database law. Resp. Br. 42-43. It failed to show that providing the requested data would interfere with its ability to create a uniform system for processing claims and disbursing benefits. *See Egelhoff*, 532 U.S. at 148; *Travelers*, 514 U.S. at 668. Even with its pages of argument in this Court about burdens, data elements, and formatting, Liberty Mutual still has not explained how providing the data is anything other than a potential administrative cost for its third-party administrator.

Second, *Travelers* and *De Buono* foreclose Liberty Mutual's argument (at 34-43) that the mere "threat" of an economic burden resulting from different state data-collection standards suffices to preempt Vermont's law. Those decisions upheld state health care programs notwithstanding the burdens they imposed on self-funded plans. Those decisions also established a rule of law under which the other 49 States might pursue analogous programs that imposed similar—though not necessarily identical—burdens. Liberty Mutual's proposed "threat" test is an effort to avoid the Court's controlling precedent and litigate here the APCD laws of other States, which have not been challenged by Liberty Mutual (or any other ERISA plan). *Travelers* does not require States to adopt identical regulations to avoid preemption.

Third, Vermont seeks standardized data on paid claims, which Liberty Mutual's third-party administrator generates in the ordinary course of business and could easily provide. AMA Br. 27; AHA Br. 21-22; CHLPI Br. 10-11; NAHDO Br. 5-11; NGA Br. 14-15; N.H. Br. 21, 27; N.Y. Br. 32-33; *see also* App. 39 (Straub, J., dissenting) ("The Vermont statute asks for after-the-fact information which plan administrators . . . already have in their possession") (citing Argument Tr. 7-8). The Health Insurance Portability and Accountability Act of 1996 "standardize[d] electronic transactions between payers and health care providers." NAHDO Br. 5-6. Vermont follows this "common set of industry-driven technical standards" adopted by the federal government. *Id.*; *see* 45 C.F.R. §§ 162.100-162.1902. "[U]se of nationally standardized codes and formats" makes "producing the claims data a minimal (or no) burden." AHA Br. 21. Liberty

Mutual belittles this standardization by noting (at 33 & n.10) that some data elements lack a nationally standardized code. But Liberty Mutual names several data elements for which Vermont has set the submission "threshold" at zero—meaning that submitted records need not include those elements. *See, e.g.*, Onpoint Health Data, *VHCURES Data Submission Guide* 41, 52 (2015), http://www.onpointhealthdata.org/clients/vhcures/docs/onpoint_vhcures_dsg_v20.pdf. Similarly flawed contentions by respondent's *amici* underscore Liberty Mutual's failure to submit relevant evidence in the district court.[8]

Liberty Mutual's third-party administrator, Blue Cross Blue Shield of Massachusetts, provides the requested data as an insurer and for other plans that it administers. *See* Pet. Br. 54-55. It is a primary contributor to the Massachusetts APCD, and its own payment models rely on claims data.[9] And *amicus*

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[8] The Blue Cross and Blue Shield Association, for example, includes a "rough" chart purportedly showing that yet-to-be-implemented ACA reporting requirements "sometimes" overlap or conflict with the database law. BCBSA Br. 26-28. As discussed above (at note 4), the ACA did not expand ERISA preemption. Moreover, the chart is not accurate; it lists items not part of VHCURES or with "0%" thresholds. *See, e.g.*, *VHCURES Data Submission Guide* 52 (setting "coinsurance amount" threshold at 0%). Another *amicus* speculates the database law would burden multi-employer plans that do not collect all requested data elements, but does not identify any such plan even covered—much less burdened—by the law. NCCMP Br. 12-13. In any event, the State regularly grants exceptions "when a payer's system does not collect a required element or has special considerations based on the population that they serve." *VHCURES Data Submission Guide* 12.

[9] *See* Ctr. for Health Info. and Analysis, *Overview of Massachusetts All-Payer Claims Database* 2 (2014), https://www.apcdcouncil.org/sites/apcdcouncil.org/files/media/state/ma-apcd-overview-2014.pdf; Blue Cross Blue Shield of Massachusetts,

Blue Cross and Blue Shield Association recently announced that its members will submit "comprehensive data on healthcare quality and costs," including data on $350 billion in annual claims, to a new database project.[10] That initiative is consistent with the Association's acknowledgement that its members enjoy "economies of scale" that "make compliance more streamlined," BCBSA Br. 33—and sharply undermines its assertion that submitting claims data is burdensome.

Liberty Mutual incorrectly asserts (at 56-67) that its use of a third-party administrator is irrelevant to the preemption inquiry. Liberty Mutual argues that Vermont's database law interferes with its ability to administer its medical plan. Yet its third-party administrator could easily and inexpensively provide the requested data. Compliance would not affect how Liberty Mutual provides health insurance to its employees.

Lastly, Liberty Mutual unpersuasively suggests that the Court should disregard the purpose of Vermont's law. Resp. Br. 30 ("[P]etitioner and the United States err by attempting to distinguish

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The Alternative QUALITY Contract 2, 8 (2010) ("global payment model" will be evaluated using "claims data"), http://www.bluecrossma.com/visitor/pdf/alternative-quality-contract.pdf.

[10] Press Release, Blue Cross Blue Shield Ass'n (Sept. 24, 2015), http://www.bcbs.com/healthcare-news/bcbsa/bcbsa-announces-industry-leading-healthcare-data-capability-to-drive-improved-quality-and-affordable-care.html. The Association plans to do "big things with big data," supporting "quality and cost improvement and further accelerating the movement toward smart, data-driven healthcare." Connecting the Dots with Data, http://www.bcbsaxis.com/#video-feature. That effort is not mentioned in its *amicus* brief. *See* BCBSA Br. 29 (describing submitting data as "time-consuming" and "resource-intensive").

between the purpose of the State law and the federal regulations."). *Travelers* rejects that position. *See* 514 U.S. at 658 (noting that both "purpose and effects" of the state law distinguished it from statutes that were preempted); *id.* at 659 (describing policy motivating state surcharges and noting that "their effects follow from their purpose"). Ignoring *Travelers*, Liberty Mutual relies (at 30-31) on *Gade v. National Solid Wastes Management Association*, 505 U.S. 88 (1992), and *Perez v. Campbell*, 402 U.S. 637 (1971). But those cases confirm that state purpose must be considered. *Gade*, 505 U.S. at 105 ("part of the pre-empted field is defined by reference to the purpose of the state law in question") (quotations omitted); *Perez*, 402 U.S. at 654 (finding conflict preemption because both the "declared purpose" and the effect of the state law "frustrat[ed] federal law"). In any event, as discussed above, Liberty Mutual has provided no evidence that the database law has any discernible effect on its ability to administer its medical plan.

III. Congress did not intend to displace state health care programs that improve public policy and allow States to do a better job of protecting public health and managing their health care systems.

States, the federal government, public health officials, insurance regulators, doctors, hospitals, and medical researchers have all conveyed to the Court that state health care databases are critical tools for improving public health and developing sound public policy. Echoing Vermont's opening brief, this broad showing of *amicus* support highlights three factors that weigh decisively against preemption.

First, state APCDs "continue and improve a long-standing practice of using health data collection to supervise public health." N.Y. Br. 21-22; *see also* NGA Br. 5-8. These databases are a better, more comprehensive version of the work States have done for decades, if not longer. *See* Pet. Br. 4-8. Collecting across-the-board expenditure information greatly increases transparency, provides real opportunities to reduce unnecessary spending, and benefits patients. *See, e.g.*, NAHDO Br. 21-27; CHLPI Br. 12-18; N.Y. Br. 9-22; AARP Br. 7-14. Liberty Mutual does not even attempt to show otherwise.[11] The Court should not lightly conclude that Congress intended ERISA as a roadblock to that "rare innovation that presents simultaneous opportunities to improve public health, reduce costs, and increase transparency." AHA Br. 16-17.[12]

Second, self-funded ERISA plans cover more than 60% of Americans who receive insurance through their employers and nearly 20% of all Vermonters. Pet. Br. 12; CHLPI Br. 20. Without their data, state

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[11] The Blue Cross Blue Shield of Massachusetts Foundation supports research using APCDs. *See* Press Release, Blue Cross Blue Shield of Massachusetts Found. (Jan. 8, 2013) (awards for projects using APCD), http://bluecrossmafoundation.org/press/blue-cross-blue-shield-massachusetts-foundation-awards-575000-policy-research-grants-advance; Blue Cross Blue Shield of Massachusetts Found., *Policy and Research Grants: 2015 Request for Proposals* 4, http://bluecrossfoundation.org/sites/default/files/download/grants/2015%20Policy%20Grant%20Guidelines_final.pdf.

[12] *See* Craig Jones et al., *Vermont's Community-Oriented All-Payer Medical Home Model Reduces Expenditures and Utilization While Delivering High-Quality Care*, Population Health Mgmt. (forthcoming) (evaluation of medical homes using VHCURES shows reduced expenditures and improved outcomes), http://online.liebertpub.com/doi/pdfplus/10.1089/pop.2015.0055.

databases would be less comprehensive, skewed toward an older and sicker demographic, and ultimately much less useful—they would "no longer provide an accurate portrait of the health of the general State population." CHLPI Br. 20-24; AHA Br. 18-20.

Third, as the United States explains, "data collected by the Vermont reporting requirements are integral to achieving the objectives of other federal statutory provisions." U.S. Br. 11. The United States, petitioner, and *amici* have all outlined ways in which the federal government supports and relies on comprehensive state databases. U.S. Br. 19-21; Pet. Br. 47-50; NAHDO Br. 30-36; N.Y. Br. 13-14. Liberty Mutual has no explanation for why Congress would authorize the federal government to provide Medicare claims data, if ERISA blocks States from collecting data from other payers. *See* Resp. Br. 49. It dismisses the grant funding that the federal government has provided for APCD development on the (irrelevant) basis that the government also provided grants for other purposes. *Id.* at 50 n.29. And Liberty Mutual does not dispute that States would need comprehensive data to "test and evaluate systems of all-payer payment reform," 42 U.S.C. § 1315a(b)(2)(B)(xi), but instead suggests creating a new federal program, unmentioned in the statute, to collect data from ERISA plans. Resp. Br. 50. The Court should not preempt state APCD laws when doing so would "frustrate the objectives of other important federal statutory provisions." U.S. Br. 19.

CONCLUSION

The decision below should be reversed.

Respectfully submitted,

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